Minutes of the

RURAL HEALTH ADVISORY COMMISSION

Thursday, September 22, 2011
6:00 p.m. – 8:30 p.m.

Holiday Inn – Kearney, NE

Members Present: Scot Adams, Ph.D.; Marty Fattig; Zach Frey, D.O.; Mark Goodman, M.D.; Shawn Kralik, D.D.S.; Rebecca Schroeder, Ph.D.; Sharon Vandegrift, R.N.; and Roger Wells, P.A.-C.

Members Absent: Kathy Boswell; Doug Dilly, M.D.; Jenifer Roberts-Johnson, J.D.; Peggy Rogers; and Mike Sitorius, M.D.

Office of Rural Health Staff Present: Dennis Berens, Marlene Janssen, and Deb Stoltenberg

Guest(s): Ethan Evert, P.T., Red Cloud, NE; Dr. Tyler and Mrs. Stephanie Adam, Hastings, NE; Richard Bischoff, Ph.D., UN-L Department of Child, Youth, and Family Studies

1. Call Meeting to Order; Open Meetings Act & Agenda Posted; Adopt Agenda; Approve Minutes of June 17, 2011, Meeting; Introduce Members and Guests

Dr. Rebecca Schroeder, Chair, called the meeting to order at 6:14 p.m. with the following members present: Scot Adams, Ph.D.; Marty Fattig; Zach Frey, D.O.; Mark Goodman, M.D.; Shawn Kralik, D.D.S.; Rebecca Schroeder, Ph.D.; Sharon Vandegrift, R.N.; and Roger Wells, P.A.-C.

After announcing that the Open Meetings Act and Agenda were posted by the door, Dr. Schroeder asked for a motion to adopt the agenda. Dr. Mark Goodman moved to adopt the agenda. Roger Wells seconded the motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius.

Dr. Schroeder asked if there were any corrections to the minutes of the June 17, 2011, meeting and for a motion to approve the minutes. No corrections were identified.

Dr. Mark Goodman moved to approve the minutes of the June 17, 2011, meeting. Dr. Scot Adams seconded the motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius.
Dr. Schroeder asked Commission members and Office of Rural Health staff to introduce themselves and stated guests could introduce themselves if so desired. Dr. Schroeder welcomed the guests and thanked them for coming.

2. Administrative Items

- **Next Meeting: Friday, November 18, 2011, 1:30 p.m. in Lincoln**
- **Discuss Nominations for Chair and Vice-Chair**

Dr. Schroeder announced that the next Rural Health Advisory Commission meeting would be held in Lincoln, Nebraska, on Friday, November 18, 2011, at 1:30 p.m.

Dr. Schroeder stated that the Commission will vote at the November meeting for a new chair and vice-chair. Dr. Schroeder commented that she has served as chair for 2 years and would like to let another member have the opportunity to serve. Marlene Janssen announced that Dr. Doug Dilly was unable to attend this meeting but did send an email indicating he would be willing to continue to serve as vice-chair. Roger Wells nominated Marty Fattig for chair and Dr. Doug Dilly for vice-chair. Dr. Schroeder announced that the slate is set and the vote will take place at the November meeting.

Marlene Janssen reported that the rural incentive program (Program 175) regulations are approved and finalized and are included in the commission members' packets.

Dr. Schroeder announced that there will be a 20-minute break to eat dinner and network.

3. Innovative Strategies for Improving Access to Mental Health Information & Services: Community Based Participatory Research (CBPR)
Guest Speaker: Richard J. Bischoff, Ph.D.; UN-L

Dr. Bischoff reported that the University of Nebraska – Lincoln, Department of Child, Youth and Family Studies has been looking for innovative ways to improve access to mental health services in rural Nebraska. Ten years ago, the UN-L Department of Child, Youth and Family Studies (UN-L Department) began providing mental health services via video-conferencing to rural high schools in counties where there were no mental health providers. Then, a few years ago, video-conferencing services were added to some rural hospitals.

About four years ago, the UN-L Department started using a process called Community Based Participatory Research (CBPR). This is a research process that has been used in different areas and ways but never to address disparities in access to mental health services. The process uses research principals where the researchers go into rural communities and partner with "research participants" as collaborators. It is action research that has community impact. This type of research process assists the community and participants to formulate the problem and see how the research effort contributes to the wellbeing of the participants and the community.

Dr. Bischoff explained that the UN-L Department identified 3 communities, St. Paul, Ord, and Albion, and then identified community champion(s) to help organize a CBPR team. Roger Wells was the community champion for St. Paul. With the help of the community champions, other people serving different areas within each of the communities were invited to an initial meeting to discuss the mental health resources in the community and the goals of the research project. The community members attending the initial meeting included representatives from law enforcement, health care, and education.

Many of these community members had never sat down and talked with the others at the table about the community's mental health resources. At one of these meetings, one mental health provider thought she

was the only one in the area but was pleasantly surprised to find out that another mental health provider at the table thought he was the only one in the area!

As researchers, the UNL Department took the lead within each community to build capacity in the community through the community champions to address the community's mental health needs. While this approach does not bring mental health providers into the community, it (1) mobilizes the resources that are currently in the community (2) gets community participants around the table and highlights what each participant can do within the community, (3) highlights within each segment, i.e., education, health care, law enforcement, of the community the differences mental health care can make to the community as a whole, and (4) creates an environment within the community to think about recruiting a mental health provider to the area.

Dr. Bischoff outlined the "keys to success" in the CBRS study as follows:

1. Have a champion, preferably more than one, within the community;
2. A critical mass of 10–15 community participants is necessary to make a difference;
3. There has to be a personal desire of the community participants to want to make a difference and stay connected by holding meetings at least once every 2-3 months; and
4. There needs to be an educational component to educate and involve residents of the community concerning mental health.

Dr. Bischoff related one of the success stories where one community started a series of mental health related lectures at the high school. Students were encouraged to get their parents to attend these lectures by being rewarded with extra credit. After the first or second lecture, people started requesting more lectures on topics such as bullying, depression, etc. Dr. Bischoff noted that one of the outcomes of the CBRS research seems to be a reduction in the stigma of mental health which helps people seek help when needed.

During the question and answer session, Dr. Bischoff stated that communities are picked based on the willingness of the community's residents/leaders to participate. He also acknowledged that the stigma of mental health is exacerbated in rural communities due to the closeness of the residents and lack of resources or knowledge of resources. Training models for mental health providers are based on an urban model and medical providers, especially in rural areas do not like to refer patients for mental health care because it's like a black hole with no feedback. Dr. Bischoff reiterated that collaboration is something the mental health providers need to work on because under the urban training model "confidentiality" is stressed over and over again which to the mental health provider means not sharing that information.

Dr. Bischoff reported that the UN-L Department has also been working on training mental health students on the use of video-conferencing. While there are no "rural training tracks" for mental health students, the UN-L Department is trying to reach out to rural areas through video-conferencing and to assist rural mental health students in staying connected to rural areas.

4. Program Committee Report

- P.T. and O.T. Shortage Area Guidelines

Dr. Mark Goodman reported on the Program Committee's conference call to address Physical Therapy (P.T.) and Occupational Therapy (O.T.) shortage area guidelines. The suggestion made to the Rural Health Advisory Commission (RHAC) was to have the health professional wanting to apply for loan repayment and/or the practice site show that no physical therapists were actually practicing in that area. The Program Committee struggled with the need for better health professions data and the cost to the State of Nebraska to obtain the data. Dr. Goodman stated that members of the Program Committee generally support projects that will help with the recruitment and retention of health professionals in rural areas; however, with this request the cost appears to outweigh the benefits.

While there was no opposition to obtaining better data, the Program Committee stressed that the data must be fair, transparent, and reproducible without additional cost to the State. Dr. Goodman stated that the suggestion to have the health professional "survey" the P.T.s or O.T.s in the area is too subjective and not reproducible. There needs to be more structure and verification in collecting this information. In addition, the professional associations did not make this request to the RHAC and the Commission would like to see the associations work with the University of Nebraska Medical Center – Health Professions Tracking Services to obtain current work "place" information.

Ethan Evert, P.T. stated that, in his opinion, what the RHAC has in place right now is not going along with what the statutes provide. Dr. Evert gave as an example a neighboring community that is a shortage area, which has been able to contract with PTs and OTs from a non-shortage area. This community has access to these services but in Dr. Evert's community there is only one PT actually working in the area and his community is not designated as a shortage area. Dr. Evert asked if the RHAC was willing to "call it quits on addressing the community's needs because what the RHAC is doing now is not effective."

Dr. Kralik responded that given the data we have available to us, what we are doing is as effective as it can be. Dr. Schroeder added that we have limited State resources. We do not have the staff time to make the calls to the clinics, to the hospitals, nursing homes, schools, etc. to collect or verify who is working where. Dr. Evert responded that this task could be given to the health professional applying for the Nebraska Loan Repayment Program. If the health professional was allowed to report the information then there would only be some double checking by the State, but that would be less costly than having State staff collect and report the information. Dr. Evert added that if the information reported by the health professional was not accurately report intentionally that would be fraud and could be dealt with by the State stopping incentive payment.

Dr. Kralik stated that the Program Committee did consider the option of having the health professional applying for loan repayment report who is or is not working in the area, but the fact is this method still involves State staff time, which we do not have. Dr. Evert reiterated that the burden would be on the local entity and health professional and if the information is not accurate the State money would get pulled. Roger Wells stated he did not think that can be done. Mr. Wells explained that the money is not "our" money, it is the State's money and we have to show the money is being used appropriately. The RHAC has the responsibility of checking to make sure the individual that is applying for loan repayment is licensed, document that he/she has government or commercial education loans, and that a local entity is willing to monitor the health professional's practice and provide the local match. To add the burden

of tracking certain health professionals adds additional responsibilities and duplicates services already available through the UNMC-HPTS.

Dr. Evert continued to bring up the fact that he thinks what the RHAC is doing now is ineffective and asked why the RHAC even bothers to offer the incentive of loan repayment to health professionals that are not tracked. Roger Wells responded that the data used is all that is available at the State and county level for the RHAC to use to determine PT and OT shortage areas. Dr. Kralik added that, unfortunately, it may not be effective but again it is all we have to use. We cannot make changes without accurate data. Dr. Kralik encouraged Dr. Evert to be the catalyst to get PT and OT professional associations to survey their professions through the UNMC-HPTS.

Dr. Goodman read the Program Committee's recommendation to the RHAC:

"The final recommendations of the Program Committee are (1) no changes to the current P.T. and O.T. shortage area guidelines and (2) work with the P.T. and O.T. professional associations and recommend that they contract with the UNMC Health Professionals Tracking Services to survey P.T.s and O.T.s practicing in Nebraska in order to provide FTE counts by county."

Dr. Ethan Evert asked if the professional associations can do the tracking and surveying or does this process have to be done by the UNMC HPTS. Marlene Janssen responded that at the Program Committee meeting it was mentioned that not all health professionals are members of their respective professional associations so the question is whether the association would survey all of their health professionals or only their members. Ms. Janssen stated that the UNMC HPTS would survey all of the health professionals in a particular group.

Dr. Evert asked how the HPTS does the surveys. Ms. Janssen stated that the HPTS is a "center" dedicated to tracking certain health professionals. HPTS started out with licensure data from the Department of Health and Human Services. Dennis Berens added that HPTS sends surveys out semi-annually and does follow-up calls to maintain the accuracy of the data. No survey is perfect but it is the most *reliable and verifiable* tracking of certain health professionals that we have available. Mr. Berens stated that obtaining information strictly from a professional association adds the risk of professional bias. The problem we have had is the professional associations have not been willing to cooperate in the effort of tracking health professionals, both members of their association and non-members. This is valuable information not only at the state-level but for the associations. The professional associations, if they would get involved, would have data to determine trends in their professionals, aging of the professionals, new professionals recently licensed, needs, etc. Dr. Evert said that what he understood from the PT Association was that this is a state issue and they (the association) did not want to get involved. Mr. Berens suggested to Dr. Evert that he ask the PT Association to invite the HPTS to give a presentation at one of their meetings. Marlene Janssen added that we could initiate a meeting with representation from the Department of Health and Human Services, RHAC, PT and OT Associations, and HPTS.

Dr. Rebecca Schroeder asked Dr. Evert how many PTs were members of the PT Association. Dr. Evert said it is probably less than 1,000 but he would find out and let the RHAC know.

Dr. Evert asked how other professionals pay for surveys and tracking. Dr. Goodman responded that surveys are supported by fees which are relatively expensive initially but the data collected is invaluable. Dr. Goodman stated, from his perspective, that Dr. Evert is a very articulate and energetic person and

suggested that he approach the PT Association again to encourage the leadership of the association to look into this issue.

Dr. Rebecca Schroeder added that this is not the first time this issue has come up. Marlene Janssen commented that pharmacists were in the same situation a few years ago but they are now surveyed by HPTS.

There was a general discussion about how health professionals are surveyed, the accuracy and reliability of the data, costs associated with surveying, and the usefulness of the data collected. Marlene Janssen explained that the HPTS is connected with other entities such as the Office of Rural Health. These entities report updated information as it is received to the HPTS and HPTS then verifies the information through telephone calls to the clinics. Dr. Ethan Evert thanked the RHAC for their time and efforts.

Dr. Rebecca Schroeder asked for a motion to approve the Program Committee's recommendation.

Dr. Shawn Kralik moved to approve the Program Committee's recommendations to (1) not change the current P.T. and O.T. shortage area guidelines and (2) work with the P.T. and O.T. professional associations and recommend that they contract with the UNMC Health Professionals Tracking Services to survey P.T.s and O.T.s practicing in Nebraska in order to provide FTE counts by county. Roger Wells seconded the motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius.

5. State-Designated Shortage Areas

- **Adams County**

Marlene Janssen reported that letters from the hospital and clinic in Adams County were received requesting that Adams County be designated as a state-designated OB/GYN shortage area. Ms. Janssen reviewed the data submitted with the clinic and the UNMC HPTS and found that there was an error in how many hours each OB/GYN physician was actually working in Adams County. After the error was corrected, Adams County does meet the guidelines for being designated as a state-designated OB/GYN shortage area.

Roger Wells moved to approve Adams County as a state-designated OB/GYN shortage area effective September 22, 2011. Dr. Mark Goodman seconded motion. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius.

Dr. Rebecca Schroeder asked guest, Dr. Tyler Adam, to comment on Adams County's OB/GYN designation. Dr. Adam said he really appreciated the Commission's action on this issue and that he worked with Marlene Janssen to resolve the data error and for all the help she provided. Dr. Adam stated that Ms. Janssen invited him to attend the RHAC meeting and that it was a "date-night" for him and his wife to attend! Dr. Schroeder commented that the commission members rarely have loan repayment applicants attend the commission meetings and thanked Dr. and Mrs. Tyler Adam for coming.

Dennis Berens asked Dr. Tyler Adam what brought him back to practice in a rural community. Dr. Adam stated that he grew up in rural Nebraska and that after his training in the Omaha area he really

wanted to connect with a smaller rural environment and give back to the community. In Omaha, Dr. Adam stated he would have been 1 of 50 OB/GYNs but in Hastings he is 1 of 4 or 5 plus the patient population is really nice!

Mr. Berens asked Mrs. Stephanie Adam about opportunities for her in Hastings because one concern that rural communities have in recruiting and retaining health professionals is employment opportunities for spouses. Ms. Adam remarked that she is actually in a very unique situation because she is an occupational therapist and is co-owner of a clinic in Papillion but can work from home. Mr. Berens encouraged Dr. and Mrs. Adam to talk to students to encourage them to return to rural.

Dr. Adam said getting students out into rural areas is essential to rural recruitment. The rural training tracks are great opportunities for health professional students.

6. Program 175 – Rural Incentive Program

- **2011-12 Student Loan Awards Update**

Marlene Janssen reported that two student loan applicants declined the student loan offers: Steven Peterson and Adam Schapmann. Both are physician assistant students. All other student loan contracts for the academic year 2011-12 have been signed and loans paid, except mental health student loan recipients will receive the second half of their student loan in February 2012. Dr. Rebecca Schroeder asked where the money goes from the student loans that were declined. Ms. Janssen replied that those funds go to the loan repayment program.

- **Loan Repayment Awards Update**

Marlene Janssen reported that there were no updates on loan repayment awards approved at the last RHAC meeting.

- **Accounts Receivable Report**

Marlene Janssen explained that the accounts receivable report was added to the Rural Health Advisory Commission's agenda as a regular report about twelve years ago. It was suggested at that time that the commission needs to be kept up-to-date on rural incentive program recipients who default on their practice obligations.

Marlene Janssen provided the following report on accounts receivable:

<u>Student Loan Update</u> (Contract Buyout and Defaults)

Bobbi Augustine, D.D.S. (Pediatric) – current (rec'd partial forgiveness then left shortage area moved out of NE)
Rachel Blake, M.D. – current (rec'd partial forgiveness then left shortage area)
Ryan Boyd, dental student – in-school buyout, full payment due 5/01/13
Cari (Brunner) Sughroue (mental health student) – paid in full as of 8/1/2011
Mary Metschke, D.D.S. – current (left shortage area)
Nicole Mitchell, M.D. – current on settlement agreement payments (non-primary care specialty, practicing in Tennessee)
Tom Pratt, D.D.S. – current (left shortage area)

Andria Simons, medical student – enrollment cancelled 01/2011; 1st Past Due Notice 8/19/11
Les Veskrna, M.D. – current (non-shortage area practice, would have been written off in 2003 but he agreed to repay the principal)
Shea Welsh, medical student – in-school buyout (principal + 6% before May 1, 2012)
Nick Woodward, D.D.S. (Pediatric) – current (left Nebraska after graduating)

Loan Repayment (Defaults – left shortage area for non-shortage area or left Nebraska)
Manda Clarke, APRN – current
Michelle Dickes, O.T. – current
Kelley Hanau, APRN – Paid in Full 7/20/2011
Joseph Kezeor, M.D. – current
Richard Michael, M.D. – current
Amanda Whitenack, APRN – current

- **Review Current Budget**

Marlene Janssen reported that if the RHAC approves all the loan repayment applications received that are eligible to begin loan repayment during FY2011-12, there will still be approximately $255,000 left in the budget to award additional loan repayment this year. Ms. Janssen stated that the $255,000 is for the state match and spending authority for the local match so technically the commission can only award approximately $127,000 in loan repayment for the remainder of FY2011-12.

Ms. Janssen reviewed the budget report with the commission and pointed out that the student loan cash fund ending balance is estimated at $445,000 by the end of FY2011-12 and will be around $285,000 by the end of FY2012-13. Ms. Janssen stated that FY2011-12 is the last year for the Merck Settlement funding and this is why the RHAC submitted a legislative request through the Department of Health and Human Services to increase the general funds for Program 175 in order to maintain the current funding level.

7. Policy Committee Report

- **Legislative Updates**

Marty Fattig provided the following legislative issues report to the RHAC:

State Issues

- The biggest issue still facing the state is the budget which is impacted by the current economic conditions.
- Legislation still needs to be passed to make provider-based Rural Health Clinics tax exempt.
- Funding for Medicaid programs is still at risk.
- The state Medicaid Meaningful Use program is not operational yet, but is scheduled to be ready by the end of October.
- Whether Nebraska develops its own Health Insurance Exchange is an issue of great importance to many Nebraskans. If Nebraska develops its own Health Insurance Exchange, Nebraska will have local control but some people are against this because it may show support for the federal health care reform legislation.

Dr. Mark Goodman left at 8:07 p.m. and returned at 8:10 p.m.

Federal Issues

- There is a great deal of uncertainty about healthcare reform. Some people are calling for a complete repeal of the bill while others are working to amend it. Because of this, it is extremely difficult to decide how to position ourselves to be prepared for whatever comes out of Washington. The health reform bill is approximately 2,400 pages long and it is anticipated that the bill will generate 24,000 pages of regulations. There are a number of programs outlined in the bill that have the potential to dramatically change the way healthcare is delivered and how providers are reimbursed. Some of these programs are: bundled payments, Accountable Care Organizations, readmission penalties, quality and comparative effectiveness, Information Technology (IT) and privacy rules, clinical integration, value-based purchasing, hospital acquired infections penalties, graduate medical education cuts, and independent payment advisory board.
- The federal budget and deficit reduction are major issues. The Super Committee has been given the task of finding ways to cut spending and balance the budget so everything is on the table including the funding of Rural Health Programs.
- The physician supervision issue is a huge issue for rural hospitals. While this issue is currently on hold, we need a permanent fix. The physician supervision issue is a rule that requires a physician to be physically present when giving certain treatments such as chemotherapy, blood transfusions, cardio or pulmonary rehabilitation.
- The physician payment issue is temporarily fixed until the end of the year. At that time, unless there is another temporary or permanent fix, physician payments from Medicare will be cut by 30%. While a permanent fix is needed the cost of a permanent fix is so high that no one in congress will vote for it in this depressed economy.
- Meaningful Use continues to move forward. Meaningful Use adoption has been much slower than the Center for Medicare and Medicaid Services (CMS) had anticipated.

(End of Marty Fattig's report.)

- **Recommendations**

Marty Fattig referred RHAC members to the Summary of Recommendations from the Policy Committee in their packets. Mr. Fattig stressed that members need to review these recommendations and provide comments to Dennis Berens or Marlene Janssen. The Policy Committee is proposing recommendations under the following general headings: (1) incentive programs for rural health professionals, (2) behavioral health services, (3) integrated service delivery and training systems, (4) rural emergency medical services and rural transportation, (5) rural communication systems, (6) rural quality, (7) strengthening rural health services by improving access to affordable health care, (8) rural managed care and reimbursement, (9) veterans care, and (10) additional rural health opportunities and issues for future consideration.

Dr. Shawn Kralik left at 8:18 p.m.

Dennis Berens stated that it is difficult to pursue legislative issues without a formal document demonstrating the Commission's work concerning rural needs. Emergency Medical Services (EMS) is a huge issue in rural areas and the underlying need is for a state statute to determine "who" is responsible for EMS. Nebraska is one of the few states in the nation that does not have such a statute.

Dr. Shawn Kralik returned at 8:21 p.m.

Sharon Vandegrift left at 8:21 p.m. and returned at 8:23 p.m.

8. A. Healthcare Workforce 2020 Task Force

Roger Wells provided the following report to the Rural Health Advisory Commission on the Workforce 2020 Task Force:

There have been approximately three meetings of the Workforce Task Force with members recommending a centralized health care workforce center to be established in Nebraska to act as a repository for health care workforce information. Presently there is a lot of duplication of services so the Task Force is recommending that a central resource center be developed to help with communication and collaboration between interested parties, act as a bridge for resources, and act as a policy link between practice and state policy which involves the supply and demand for collective resources and recommendations.

Vision: The Nebraska Health Care Workforce Center will be an essential resource, trusted partner and unique venue for Nebraskans to promote health and health care workforce developments. This collaborative effort will result in a competent, diverse and sustainable workforce.

Mission: The Nebraska Health Care Workforce Center creates and facilitates opportunities to collaboratively address issues and challenge the delivery of comprehensive, high-quality health care throughout the state in the center. This center promotes health care workforce development through enhanced interdisciplinary communications, analyze health care workforce needs, and identify strategic solutions and advocates for achievable outcomes.

Priorities: (1) Serve as a centralized resource that provides health care workforce information to the current and potential health care workforce, policy makers and community at large; (2) Consolidate state-wide data; and (3) Offer strategic solutions that promote health care workforce development.

At this time, we are looking for a coop funding option that would provide uniform involvement and contributions from all partners and/or grants that would be pursued at the federal and local level. The Task Force is hopefully that the center would be underwritten, hopefully, by a larger corporation for at least a startup as a financial incentive.

This would be a stand-alone, autonomous organization in order to remain impartial and objective. This type of structure is deemed necessary for the center to service as a centralized resource for all unbiased factual information to policy makers and community at large; also offering strategic solutions to promote health care workforce development.

(End of Roger Wells' report on Workforce Task Force)

B. National Advisory Committee on Rural Health & Human Services

Roger Wells gave the following report on his work on the National Advisory Committee on Rural Health and Human Services:

The National Advisory Commission for Health and Human Services recently met in Michigan for a three day meeting spending most of the time considering the issues in the Affordable Care Act and how

they affected primary care, the home visitation rules for visiting nurses, and value-based purchasing demonstration projects for Critical Access Hospitals.

Concerning primary care implications of the Affordable Care Act, the commission is recommending that the Secretary of Health and Human Services: (1) allow National Health Care Service Corps (NHSC) participants to be placed in the geographic area of their choice; (2) allow part-time nursing students to be enrolled in advanced practice nursing programs and be eligible for NHSC scholarship programs even though the participation level may be minimal; and (3) study rural training tracks of medical education and residency programs to see how they are distributed and whether or not they are successful since so many areas are not productive at all in their placement or success in placement of rural health participants in the program.

With regard to the value-based purchasing demonstrations for Critical Access Hospitals, the committee recommended secondary group Critical Access Hospitals and other low-volume hospitals with their peers to be based upon their average daily census rather than being compared to national standards. Also, it was recommended that the Secretary use clinical inpatient measures that are specific for the characteristics of low-volume hospitals such as heart failure, pneumonia, etc. rather than trying to associate them with successful specialty-based hospitals. Financial and efficiency measures should also be utilized in comparison of the in-like hospitals rather than the disincentive of cost reductions as planned at this time. The reduction in cost of administrative services and care practices improve the value base of rural communities compared to larger hospitals. Also, technical assistance and support of clinical and financial performances through the Medicare Quality Improvement Organizations (MQIO) would help hospitals develop quality; however, at this time the disincentive is there are no individuals available to make these adjustments at this time in small hospitals.

Therefore, in summary of this agenda, the committee recommended the Secretary to direct CMS to fund incentive payment programs, actuarially projected rather than evaluations done by outside sources.

Final paper is aimed at the rural policy implications for maternal infant and early childhood visitation programs. This project identified that most of these rural areas are not utilized even though it was the initial intent of the program because of lack of funding, lack or resources, etc. Therefore, the committee recommended that the Secretary provide technical assistance for evaluation of the promising approach as to states who have actually implemented the high need areas rather than low need areas as presently utilized. The committee recommended that the Secretary of Health and Human Services require states to collect urban, rural community data that would allow meaningful use to actually occur in a rural setting.

(End of Roger Wells' report of the National Advisory Committee.)

Dennis Berens announced that there is going to be a national meeting of RTT (Rural Training Tracks) in Nebraska around the first week of March 2012. Nebraska has the most rural training tracks in the nation with four tracks.

Roger Wells stated he is working on trying to get the national committee to come to Nebraska for a meeting. He asked for support from the RHAC and Office of Rural Health.

9. CLOSED SESSION

- **Review Loan Repayment Applications**

Roger Wells moved to go to closed session at 8:36 p.m. to discuss loan repayment applications. Marty Fattig seconded motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius.

Dr. Rebecca Schroeder announced that the RHAC would go into closed session at 8:36 p.m. to discuss loan repayment applications and asked guests and non-essential staff to leave the room.

Note: During Closed Session, Roger Wells was asked to leave the room at 8:39 p.m. when the RHAC needed to discuss an application that Mr. Wells had a conflict of interest in.

10. OPEN SESSION

- **Motions on Closed Session Discussions**

Dr. Mark Goodman moved to go to open session at 8:40 p.m. Dr. Shawn Kralik seconded motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, and Vandegrift NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, Sitorius, and Wells

Dr. Mark Goodman moved to approve the following loan repayment applications with the 3-year practice obligation beginning as indicated:

Reed Miller, PharmD, 8/1/2011
Andrew Carter, PharmD, 9/1/2011
Christine Hanson-Harder, O.T., 9/1/2011
Kristine Kleve, P.T., 9/1/2011
Tyler Adam, M.D., 9/1/2011
Paul Willette, M.D., 10/1/2011

and move Dr. Michael Donner's application to the waiting list. Roger Wells seconded motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius. (NOTE: Marty Fattig abstained from voting on Reed Miller's loan repayment application due to a conflict of interest.)

Dr. Mark Goodman moved to approve the request from Oakland Mercy Hospital to have Lea Wells, P.A. receive full-time benefits under the Nebraska Loan Repayment Program effective October 1, 2011. Marty Fattig seconded the motion. Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, and Vandegrift. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius. Roger Wells recused himself from the vote due to a conflict of interest.

11. Other Business

- **Medicaid Magellan Update**

Dr. Scot Adams reported that the complexity of the issues makes this a very confusing time. The dynamics concerning adult behavioral health services focuses on a little known issue called the "IMD rule" created back in the 1960s. (IMD means Institute for Mental Disorder.) Medicaid did not want to

pay for patients with mental illness living in a free-standing facility with more than 16 beds dedicated to mentally ill patients or in a hospital with 50% of the beds occupied by mentally ill patients. This particular rule has been ignored "all across America" but now the Center for Medicare and Medicaid (CMS) is cracking down on facilities and enforcing the rule.

Dr. Adams stated that there was some hope that the Affordable Care Act (ACA) would create a challenge to the IMD rule. There are two demonstration projects to keep the IMD rule in place with some exceptions such as emergency rooms. However, providers do not like the IMD rule because it creates an inefficient system of care. Consumers tend to like the IMD rule because they would prefer not living in an institution but rather living in an apartment integrated into society. The proposed solution will be for states' behavioral Medicaid program to go to an at-risk managed care environment. The Medicaid rules allow for that type of waiver to the IMD rule.

Dr. Adams reported that there is a parallel to the IMD rule in the children's behavioral health rules. Privatized Psychiatric Residential Treatment Facilities (PRTF) were created to treat children with behavioral health concerns but CMS viewed this as too many people "ghettoizing" in one place. So providers of children's behavioral health care have been discontinuing services because of not being able to develop a treatment for care that is acceptable under the IMD rule. At the same time there is an effort to develop public-private partnerships between child welfare which includes behavioral health and a whole lot more such as neglect, foster care, abuse, etc. While behavioral health is part of the child welfare it is not the whole universe of the public-private partnership.

According to Dr. Adams, Nebraska is about in the middle nationally on the number of behavioral health in-patient beds. A major concern with the IMD rule is if a patient lives in an IMD facility where the diagnosis and treatment is for mental illness, he/she risks losing Medicaid benefits for *health care*.

Dr. Mark Goodman asked how elder patients with dementia living in nursing homes are treated. Dr. Scot Adams replied that dementia is not included in the behavioral health definition and can be treated as a medical condition. Dr. Adams stated that each institution is reviewed to determine if it is or is not an IMD facility. This is based on the ownership, general care provided, etc. In summary, Dr. Adams stated that CMS and the U.S. Department of Justice are both involved in determining if states are complying with all the various laws concerning treatment centers and housing for persons with mental illness.

12. Adjourn

Dr. Mark Goodman moved to adjourn at 9:00 p.m. (No second necessary, requires immediate vote.) Motion carried. YES: Adams, Fattig, Frey, Goodman, Kralik, Vandegrift, and Wells. NO: None. Excused: Boswell, Dilly, Roberts-Johnson, Rogers, and Sitorius.